March 13, 2026

Via email: regulations@wcb.ny.gov
New York State Workers' Compensation Board
328 State Street
Schenectady, New York 12305-2318

Re: Proposed Amendments to Sections 329-1.3, 329-4.2, 333.2, 343.2, and 348.2 of Title 12 of the NYCRR (Medical Fee Schedules Update)

To Whom it May Concern:

On behalf of the New York Insurance Association (NYIA), thank you for the opportunity to comment on the New York State Workers Compensation Board proposed amendments to the medical fee schedules. NYIA represents property and casualty insurers that underwrite and manage risk across all counties of New York and rely on these fee schedules to provide vital medical services to injured New Yorkers. We are weighing in on the impact on workers compensation but given the use of the fee schedules for no-fault auto insurance, are providing comments in relation to auto at this juncture as well.

NYIA appreciates the Board's recognition of the need to modernize the medical fee schedules and its efforts to update and align them with current medical practices. Our members value the Board's commitment to improving the system and acknowledge the importance of ensuring that reimbursement structures remain accurate, contemporary, and administratively workable. At the same time, NYIA member insurance companies have expressed several concerns and questions regarding the proposed amendments—particularly with respect to the potential for increased medical costs, the implications for claims handling processes, the clarity and consistency of certain procedure codes, and the expansion of codes added as "By Report." We welcome the opportunity to raise these issues and seek further clarification to ensure the updates promote both quality care and systemwide stability.

The proposed changes to the fee schedules based on the analysis by insurance companies are expected to dramatically increase costs well beyond the 2–3 percent system-wide impact originally projected. In particular, reimbursement rates for Evaluation and Managements (E&M) codes for MDs, DOs, NPs, and PAs—specifically within the 9920_ and 9921_ series for new and established patient evaluations—are poised to rise sharply. Companies are anticipating increases far exceeding 3 percent for E&M CPT codes, Relative Value Units, and Conversion Factors, with an estimated average cost increase of approximately 43 percent for services rendered in Region IV for CPT Codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

Additionally, some of our members pointed out that the most frequently paid codes over the last three years, CPT 99204, 99213, and 99214 are projected to increase by 41 percent, 78 percent, and 73 percent respectively. Because CPT 99213–99215 reflect services commonly provided on a recurring basis throughout a claimant's treatment, these increases compound over time, significantly elevating overall costs to insurers. It remains unclear whether the methodology used to calculate the projected system impact appropriately accounted for the recurrent nature of these high-volume codes. Furthermore, greater transparency regarding how the 2–3 percent estimate was determined would be beneficial to carriers in determining how the Board perceives these increases.

Additionally, the proposed changes would substantially alter how certain claims are submitted and reviewed, introducing new administrative complexities for both providers and carriers. The expansion of narrative documentation requirements across multiple schedules, now mandating specific elements such as work status and causal relationship, raises practical questions about enforcement, including whether these elements are required for bill acceptance or payment, whether a missing element renders a bill incomplete, how strictly carriers are expected to enforce the standards, and whether the existing medical narrative report template is intended to be mandatory for E&M services or if equivalent documentation will remain acceptable. Because electronically submitted bills lacking required attachments are automatically rejected, clear guidance will be essential to prevent unnecessary rejections, resubmissions, and disputes.

The proposal also formalizes telehealth within the fee schedule rather than relying primarily on website guidance, making clarity even more important regarding whether future webpage updates automatically control, how modifier and place-of-service requirements should be applied, and whether telehealth-specific documentation obligations exist. Our membership further supported permanent telemedicine restrictions added related to eligible codes for certain specialties (GR21) as this clarification would be crucial to limit inappropriate use of telemedicine services.

Additionally, while the effort to address out-of-state treatment is a positive step, further direction is needed on whether bills using non-NY CPT codes may be denied and whether PAR requirements apply uniformly to out-of-state providers, many of whom may be unfamiliar with New York's unique rules, so as to avoid unnecessary disputes. Secondly, the proposal introduces substantial CPT code set changes, including additions, removals, and revisions to RVUs and descriptions, along with modifications to numerous ground rules. Given the scale of these changes, concerns arise regarding system implementation, the potential need for a grace period, and whether software updates will be required to ensure accurate processing. Clear, timely guidance will be critical to ensuring a smooth transition and reducing the risk of preventable payment or denial errors.

Furthermore, as revisions to the fee schedules move forward, this rulemaking period offers an important chance to eliminate long-standing confusion about the correct use of several CPT

codes that are frequently misapplied. A recurring challenge involves CPT 99358, which some providers use when administering outcome-assessment questionnaires. These questionnaires, however, function as extensions of the routine clinical evaluation rather than as a separately billable service. While Workers' Compensation reviewers often reject these charges, no-fault decisions are far less consistent, allowing the practice to continue in ways that drive up costs and fuel avoidable disputes. Clear, authoritative direction in the fee schedule would help curb these inconsistencies across both systems. Similar challenges arise from the divergent treatment of CPT assistant guidance; workers' compensation determinations frequently rely on it, whereas no-fault tribunals tend to give it little weight, resulting in conflicting interpretations of the same billing rules. Explicit incorporation of key principles directly into the fee schedule would align expectations across forums.

Additional clarification is also needed for Anesthesia Ground Rule 1B, which is currently drafted in a way that leaves open the question of whether an anesthesiologist and a CRNA may both bill for the same anesthesia service. Stakeholders need to understand whether the rule permits reimbursement to only one provider or to both, and how the proposed amendments are intended to apply—particularly with respect to whether dual billing is allowed and, if so, at what reimbursement percentages. Clear guidance on these coding issues would help ensure uniform billing practices, reduce unnecessary litigation, and promote a more predictable reimbursement environment.

Lastly, the proposal also significantly expands the number of services designated as "By Report" (BR), creating substantial uncertainty in how these procedures will be billed, evaluated, and reimbursed. This includes several physical medicine–related codes—97037, 0552T, and 0770T—that function as alternatives to modalities already capped under existing daily RVU limitations. Leaving these codes outside the RVU-capped structure would create disparities in how comparable therapies are regulated and could unintentionally encourage providers to shift toward higher-priced BR services. For that reason, these three codes should be incorporated into the physical medicine ground rules across the Medical, Chiropractic, and Acupuncture/Physical & Occupational Therapy fee schedules to ensure consistent oversight.

Similar concerns arise with CPT 95941, which remains a BR code and, as a result, generates wide variation in charges and requires extensive review to support or challenge pricing. Establishing an RVU—such as 26.64, which aligns reimbursement with three hours of monitoring under current 95940 values—would bring clarity and predictability to this service. If assigning an RVU is not feasible, the proposed regulatory language limiting charges for 95941 to no more than the equivalent cost of 95940 should be formally adopted to prevent inflated billing.

Additionally, the temporary health and well-being coaching codes (0591T–0593T) have also been placed in BR status, despite reflecting non-clinical services that are highly dependent on provider qualifications. To avoid inconsistent billing and to ensure that only appropriately trained professionals render these services, the fee schedule should specify that they must be performed

by coaches certified by the National Board for Health & Wellness Coaching. Clear direction on these BR codes will help prevent abuse, support consistent reimbursement practices, and reduce administrative and legal disputes.

Thank you for your time and careful consideration of our comments. We appreciate the Board's ongoing efforts to refine the Workers' Compensation fee schedules and its attention to the concerns raised by stakeholders. As outlined in this letter, many of the proposed changes are expected to significantly increase system costs and introduce meaningful shifts in how claims are submitted, reviewed, and adjudicated.

We also value the opportunity to highlight areas where additional clarification would be particularly beneficial, including the proper application of several specific CPT codes and the reconsideration of the numerous services newly assigned "By Report" status. We respectfully request that the Board continue to refine these provisions to ensure predictable reimbursement, consistent claims handling, and a fair and efficient process for all participants in the system.

As always, please feel free to contact NYIA if you have any questions or wish to discuss this matter further. Thank you for your consideration of our comments.

Sincerely,

Cassandra Anderson
President